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ABSTRACT

On the basis of the relevant research literature, this article discusses adult sleepwalking disorders, and focuses particularly on the documented cases of violence occurring during sleepwalking. Important diagnostic elements are reviewed, including family history, age of onset, gender, stages of sleep, impairments in memory and judgment, automatic nature of behavior, the role of trigger factors (such as drugs, alcohol, excessive fatigue, and stress), and the potential risk of harm to the bed partner. Treatment recommendations are discussed, including using no drugs, taking special precautions, maintaining a regular sleep-wake cycle, and getting a complete assessment by a sleep expert. The central forensic issues are outlined, focusing on diagnostic elements and issues related to criminal responsibility. A case study is presented of a 27-year-old father of four who had been charged with assault and battery, allegedly having assaulted his wife in the night with a broken bottle. The case study is presented in detail and concludes with a summary of clinical opinion. (Author/ABL)

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# Murdering While Asleep: Clinical and Forensic Issues

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# MURDERING WHILE ASLEEP: CLINICAL AND FORENSIC ISSUES

## Clinical Issues

Sleepwalking is a known psychiatric disorder: DSM-III-R 307.46. However, this disorder is rare amongst adults. It is exceedingly rarer for violence to accompany sleepwalking in adulthood. And yet, the research literature has documented some of these rare events (Howard & D'Obran, 1987; Kavey et al., 1990).

### Diagnostic Elements

1. A family history may be present. The disorder is more common in first degree biologic relatives. The disorder tends to occur in 1%-5% of the general population. However, as many as 15% of all children may experience isolated sleepwalking episodes.

2. Adult sleepwalkers typically started sleepwalking at a later age in childhood, whereas the typical onset of sleepwalking is commonly in early childhood (almost always before age 10), and is usually outgrown by age 15. The literature indicates that it is highly unusual for sleepwalking to start after adolescence. Adult onset sleepwalking is rare, and usually only occurs with a precipitating cause, such as head injury. Regard with suspicion any episode of sleepwalking when the first episode is said to occur as an adult.

3. Sleepwalking tends to be more common amongst males.

4. Episodes of sleepwalking occur only during delta slow wave sleep, and thus are most likely to occur within two hours of sleep onset. Two-thirds of all sleepwalking episodes occur in the first non-REM period. The body is not paralyzed during slow wave sleep as it is during REM sleep (when dreaming occurs). The episode can last from a few minutes to about a half hour.

5. Sleepwalkers may either return to bed without ever reaching consciousness, or may lie down in another place to continue sleeping.

6. During the episode, the sleepwalkers often have a blank stare, and are relatively unresponsive to the efforts of others to influence the sleepwalking or to communicate with them. They can be awakened only with great difficulty.

7. When sleepwalkers do finally awake, there usually is disorientation on awakening. A straight arousal into clear consciousness is unlikely to occur on awakening from sleepwalking. It may take 5-10 minutes for persons to become fully awake, as opposed to REM sleep when the person would awaken directly into consciousness.

8. There must be amnesia for the sleepwalking episodes. Sleepwalkers' memories are poorly recorded during stage 4 sleep and poorly recalled. Memories of sleep mentation should be that of stage 4 sleep: non-narrative, non-dreamlike, with only a vague visual content, consisting mostly of thoughts and feelings. Fragmentary dream images may be recalled, but not complete dream sequences.

9. Sleepwalking behavior is usually automatic, and tends to be carried out in a mechanical and crude manner that is more or less integrated and appears to be at least semi-purposeful. Coordination may be poor and there may be some element of confusion; nevertheless, sleepwalkers may be able to negotiate their way around obstacles, carry out searching movements with their eyes, and show a high degree of responsiveness to the environment. For example, sleepwalkers can usually carry out semi-purposeful acts many of which are highly complex. They may dress or partially dress, open and shut doors, eat, and go to the bathroom, though such behaviors may be clearly out of context, and reflect the sleepwalkers' general lack of awareness.

10. However, the sleep walking behavior may be out of character for the persons, inappropriate for the circumstances, lacking in judgment, and may put them at risk for physical harm. For example, sleepwalkers are known to have taken dangerous routes, such as walking out onto fire escapes, firing guns, and driving cars, with injury to self or others.

11. Usually there is no history of significant EEG abnormalities, such as epilepsy or evidence of metabolic disturbance. DSM-III-R diagnostic criteria for sleepwalking requires that it cannot be established that an organic factor initiated and maintained the disturbance.

12. If night terrors are present (they are in an estimated 55% of sleepwalkers), the sleepwalking is likely to be more vigorous and frantic than the simple somnambulistic episode.

13. There may be trigger factors; drugs, alcohol, excessive fatigue, and stress, can all precipitate sleepwalking. Sleepwalking is more likely to occur if persons have been losing sleep (resulting in a sleep deficit and a "slow wave/delta sleep rebound") in which they sleep longer in the slow wave delta period thus making it more likely for sleepwalking to occur. Sleepwalkers also tend to report the occurrence of a major life stressor at the time of the first onset of their disorder, and that mental stress increases the frequency of their episodes. Alcohol, sleep deficit, and excessive fatigue may cause sleep to be exceptionally deep, and this has been correlated with sleepwalking. A variety of drugs with differing pharmacological actions may affect the physiology of sleep and may produce sleepwalking reactions in susceptible individuals.

14. There may be no psychiatric history. Sleepwalking is not necessarily correlated with any underlying severe psychiatric abnormality, it is not a hysterical condition, and it is not necessarily a manifestation of a more pervasive mental illness. Sleepwalking is primarily a physiological phenomenon that cannot be understood in psychological terms, and it may not be possible to establish causal psychological activity. Sleepwalking has been observed in completely normal persons.

15. Nevertheless, some studies (e.g., Kales et al., 1980; Sours, Frumkin & Indermill, 1963) have suggested that adult sleepwalkers may have symptoms of other mental disorders, such as personality disorders. These studies have suggested that adult male sleepwalkers tend to have more immature and inadequate dependent personalities and tend to overcompensate for a lack of self-confidence by a scrupulous conformity and avoidance of competition, and show active, outwardly directed behavioral patterns suggesting difficulties in handling aggression and frustration. For example, such persons may struggle with life frustrations poorly, and failure and loss of self-esteem may be more outwardly directed rather than inner directed. These studies also suggest that male sleepwalkers may have inadequate identification with a male figure, and their fathers have tended to be alcoholic, abusive, or inadequate, and may have vacillated between profound passivity to pseudoaggressiveness. The mothers of adult sleepwalkers, on the other hand, may have been domineering, controlling, and covertly disparaging of their husbands. This has led some to suggest that adult male sleepwalkers may have intense oedipal problems (viz., a need to run away from the bed). Impulsive difficulties, including marrying impulsively, may also occur with adult male sleepwalkers.

Treatment Recommendations

1. Using no drugs, alcohol, or caffeine, and using no psychiatric medications unless prescribed by a physician who is aware of the potential of any medications to exacerbate sleepwalking. Sleepwalkers should avoid any over-the-counter cold remedies or diet pills that contain stimulants.

2. Taking special precautions, such as placing locks on doors and windows, tying one's ankle to the bedpost, and placing a "kiddie fence" by the bedroom door can help.

3. Sleeping on the ground floor.

4. Getting psychiatric help for depression and/or other concurrent emotional problems.

5. Learning stress management skills, and providing reassurance, to lower anxiety.

6. Maintaining a regular sleep-wake cycle, and getting adequate sleep at regular intervals.

7. Seeking vocational assistance for job training.

8. Receiving marital counseling.

9. Getting a complete assessment by M.D. expert in sleep disorders, including monitoring physiological measurements needed to determine the different stages of sleep.

## Forensic Issues

### Diagnostic Elements

1. There may be a previous history of violence during sleepwalking.

2. Sleepwalkers' spouses may complain of being kicked, bruised, and sometimes threatened; the spouses may awaken to find their partners' hands on their body or even around their neck.

3. Any violent crime that is committed while sleepwalking may be motiveless and totally out of character for the person. Usually there is no preexisting animosity to the victim. The violent act may be completely senseless.

4. There must be no attempt to conceal the assault. The natural response of the sleepwalker should be to summon help immediately upon awakening.

5. Night-terrors may be experienced. A history of violent behavior is significantly more often reported by subjects suffering from night-terrors.

### Issues related to criminal responsibility

1. The central forensic issue with a sleepwalking disorder appears to be: were the sleepwalkers aware of what they were doing, or, on the contrary, were they in a state of "automatism" in which involuntary movements of the limbs or body were carried out without conscious knowledge or without control?

2. An automatism is defined as the involuntary movements of the limbs or body which are carried out without conscious knowledge or without control, are usually inappropriate for the circumstances, and may be out of character for the persons.

a. An "insane automatism" refers to those which arise from an internal disease factor, e.g., epilepsy, brain tumor, vascular confused state. The legal disposition in these cases may be commitment to a hospital.

b. A "sane automatism" refers to those acts which arise from a so-called external factor in the absence of a mental disease, such as a hit on the head. The legal disposition in these cases may be that sleepwalkers are freed from court; they cannot be held legally responsible for their behavior because they were not conscious of their actions.

3. Sleepwalking is often classified as a sane automatism because of the absence of any clear cut brain pathology or mental illness. The literature suggests that during sleepwalking, the mind may not go with what is being done. Thus, sleepwalkers might not be held legally responsible for their behavior because they were not conscious of their actions.

4. A criminal offense that occurs during sleepwalking would be judged on the "actus reus" element in the crime. Since the sleepwalker's actions are not consciously willed, they may be considered involuntary and not an "act" for criminal liability purposes.

## Case Study

A twenty-seven year-old, separated, Caucasian male and father of four was admitted from a local district court in the Boston area. He had been charged with assault and battery with a dangerous weapon. He was alleged to have assaulted his wife with a broken bottle during the night.

### Account from the defendant's wife, victim of the assault

At approximately 12:30 a.m., the defendant's wife reports that she awakened to discover her husband lying on top of her, and she felt pain on her face. She discovered that he had taken a piece of glass, and had cut her face several times by making several quick surface cuts which drew blood. She states that her husband had apparently gotten out of bed, and gone to another part of the house to get a piece of glass which she had earlier brought into the house because they live in a rough neighborhood, and she felt that it would be for her family's protection not to have broken glass lying around outside the apartment. While he was cutting her, she states that he was also saying to her: "You have no right to be sleeping with your psychiatrist." She then states that she attempted to push him off of her, and managed to do so; but then he twisted her arm, and threw her up against a wall. At that point, she said that she screamed.

She next reports that her husband walked around the bedroom for a few moments staring into space, and she knelt in a corner hiding behind a chair. Then, he returned to bed. At that point, she left the bedroom and called her two former roommates on the phone, and asked them to come get her. She also called the police, and they instructed her to take a taxi to a local hospital. She proceeded to pack her clothes in a suitcase, and she also attempted to medicate her facial wounds as best she could. When she later returned to the bedroom about forty-five minutes to one hour after the assault, she states that he was then sitting up in bed, and she told him: "Look what you did to me, you bastard." She states that he replied: "What, come here, what?" She then told him: "How could you do this, you promised me." At that point, she states that he put his head down, and said he was sorry, and told her that he would have to get help. She also recalls him saying: "I don't know why I take this out on you."

### Defendant's version of the assault on his wife

The defendant reports that on the evening of Oct. 31, he and his wife had taken their children out for trick or treating. He states they had had a delightful time, and indicates that there had been no arguments or tension. However, he admits that he was drinking rum and coca-colas when they returned home. He states that he and his wife went to bed around 10 p.m. Prior to going to bed, he states that his wife gave him some Klonopin 4 mg tablets to help him sleep. The next thing he recalls is that his wife is crying in the parlor, saying: "You promised

me you wouldn't do it anymore." When he saw that she had been bleeding from the face, he recalls feeling very guilty and "sick" of his behavior. He states: "When I woke up, I was bewildered; then I knew that she was dressed and ready to leave the apartment."

After she left the apartment, he states that he felt so guilty that he proceeded to strike himself and inflicted facial wounds on himself. He also states that he called the police because he wanted to see if she was okay. Later, he reports that six police officers came to his door, and he accompanied them without incident to the station. Some of the officers remained behind in the apartment because the four children were sleeping, and they remained there until his wife returned.

The defendant has no memory of assaulting her in any way.

Sleepwalking history

The defendant reports that his first known incident of sleepwalking occurred when he was nine or ten years old; at that time, he was later informed that he had sleepwalked into a closet and urinated, thinking it was a bathroom. He also recalls that his younger brother sleepwalked when he was very young (suggesting possible familial pattern to the behavior). He cannot recall any incidents of sleepwalking during his teenage years; since he would not to be able to recall sleepwalking unless someone informed him, I checked with his parents, and they did not know of any sleepwalking incidents during his teenage years.

However, according to his wife, she witnessed multiple sleepwalking incidents during their nine year marriage. These incidents included his driving a car on two occasions, walking up and down the stairs in their three story apartment building in his underwear (1984 - 1989), walking up and down the streets of the neighborhood pushing a baby carriage and banging on neighbors' doors telling them there was a fire and causing the local police to think he was on drugs (1982), dancing with his daughter in the kitchen while they were both asleep (1988 or 1989), and making weird snacks for himself in the kitchen. She recalls that on one occasion in 1988, she got up to go to the bathroom, and he asked her to shut off the light in the hallway outside their apartment; when she did, she states that he locked her out of the apartment. During these incidents, she states that his behavior was purposeful, controlled, and coordinated.

With regards to his history of assaulting her during sleep, she states that the first time he assaulted her while sleeping was in 1982 when he picked up a phone and started hitting her over the head with the phone. She also reports numerous instances of waking up and finding his hands around her throat, kicking her, punching her, and pulling her hair. When these incidents occurred, she states that she pushed him away and he always returned to sleep.

His wife states that his sleepwalking always occurred during the first three hours of sleeping. The couple usually went to bed around 10 p.m., and she indicates that his sleepwalking always occurred between 11 p.m. and 1 a.m.; on these occasions, she tried to awaken him by slapping him, speaking to him, or throwing water at him, but nothing awakened him. She states that when he woke up the next morning, he was never able to recall the sleepwalking.

In terms of frequency, the defendant's wife states that up until the past year, she has known her husband to sleepwalk about once a year. However, during the past year, she reports that his sleepwalking escalated to approximately once a month. She reports that he has been under increasing stress because he has been out of work, and they have had four children to support. She also states that he has been trying to lose weight, and has been taking diet pills. Furthermore, he has also been stressed by the fact that she was experiencing an emotional breakdown that required hospitalization in August 1989 following two suicide attempts.

Eyewitness account

There is one independent eye witness to his sleepwalking, and that is a former resident of the apartment building where the couple lived. This witness reports that she personally observed the defendant sleepwalking on three or four occasions, most recently in June 1989 before she moved out of the building. She lived on the third floor, and the couple lived on the second floor. At around 1 a.m., she would hear someone walking in the hallway, and would open the door and find the defendant walking up and down the stairs in his underwear; she states that he was "spaced out." She would attempt to call to him, but he did not respond. She then would awakened his wife by knocking on her door. She states that his wife would attempt to wake him up, but she could not. Then, his wife would take him by the arm, and would lead him back to the apartment. At no time did the eyewitness feel that he might harm either of them, and she did not observe any violence exhibited by him towards his wife.

Psychosocial history

A thorough psychosocial history was taken that included multiple interviews with the defendant, an interview with his parents, two interviews with his wife, an interview with an independent eyewitness to his sleepwalking behavior, telephone consultations with two physicians at sleep disorders clinics at two Boston area hospitals, and a thorough background check for any prior criminal behavior.

The defendant was born in the Boston area; he was a full term baby and had no developmental difficulties. He was the middle of three children, and he had one younger brother and one older sister. During his growing years, his father worked as a warehouseman, and his mother worked at a local company.

The defendant reported that he had had a conflictual relationship with both parents for many years. Although he denied any physical or sexual abuse, he felt that he was emotionally abused. He described his mother as jealous and controlling. He resented his father for being emotionally uninvolved with him in any positive way. He never saw much of his father because his father worked the third shift and also worked lots of overtime, and slept most of the day. As a result, the defendant felt that his father wasn't very interested in his children. He also recalled that his father was critical and sarcastic, and sometimes called him a "baby" and a "sissy" when he was young. The defendant felt that his sister and brother were particularly favored over him, and felt that he was "overlooked" by his parents. He also indicated that his father had alcohol problems, and that his sister had been a drug abuser and was a recovering alcoholic.

His mother admitted that her son was not raised under the best of family circumstances. She reports that when the defendant was one year old, her own mother died suddenly in an auto accident. As a result, she found herself having to raise her sister and brother in addition to her own three children. Then, when the defendant was seven, she reports that her own sister committed suicide. She felt that these two traumatic events occurred so close to one another that she did have the opportunity to appropriately mourn the loss of her relatives because the pressures on her were so great. She indicated that she became severely depressed and angry that her mother had died and had left her with three teenagers; she also felt guilt over her sister's suicide. She felt that everything was falling apart for her, and felt guilty about her children. As a result, she felt that her son didn't have "a part of her that he needed." Three years ago, she stated that she tried to tell her son that she had suffered as well; she wanted him to know that "she had pain, too," and that "he wasn't the only one who had insecurities."

The defendant received B's and C's in grammar school, but "goofed off" in high school and received only C's and D's. He did not participate in extra-curricular activities because he felt he lacked the self-confidence to do so.

He was married ("impulsively") one year after graduating from high school in 1981. His wife was pregnant with their first child at the time of their marriage. After graduation from high school, the defendant worked construction until an industrial accident placed him on workers' compensation. Beginning in 1983, he worked for approximately three years for a roofing company. In 1985, he began a three year stint working as a meat trimmer. In 1987, he made an unsuccessful attempt to run his own donut shop. He then returned to his job as a meat trimmer, where he worked until November 1988, at which time he was fired for taking too much time off work to assist his wife through a difficult pregnancy.

For the past year, he and his wife have been receiving AFDC. They have four children (three girls, one son), ranging from fourteen months to eight years.

Recent history

During the two months prior to the assault, the couple had been separated. The defendant had been going to a nearby counseling center for help with his sleepwalking disorder. The defendant's wife had been away from her husband during the months of August and September when she had been hospitalized in the psychiatric unit of a nearby hospital; she reports that she had become depressed and suicidal when she had recently begun to recall incidents of childhood sexual and physical abuse at the hands of her mother. During her hospitalization, the defendant had custody of the four children. When she was discharged, she elected not to return home to be with her husband and children because she was afraid of her husband's prior assaultive behavior at night. Therefore, she went to live with friends.

During the month of October, the defendant admits that he became very depressed, and felt guilty for his sleepwalking behavior and assaults on his wife; he also reports that he had thoughts of committing suicide by cutting himself with a razor blade, but decided not to do it because of his children. He began to worry that he might be a single parent for the rest of his

life, being on welfare, and not being able to give his children the kind of life he wanted to. By his own admission, he became a "nervous wreck." He also states that he felt increasingly inadequate in part because of being overweight. Thus, he went on a crash diet to lose weight in order to attempt to make himself more attractive to his wife; he used caffeine-containing diet pills to help accelerate weight loss, and indicates that he lost a substantial amount of weight (he states that he went from 300 pounds to 260 pounds in the month of October. He also reports that he had trouble sleeping, was staying up until 3 a.m. - 4 a.m. watching TV, and he was also drinking nightly concoctions of rum and coca-cola. He states that it was a real shock to have his wife leave him because "my wife is everything to me." He feared being alone for the rest of his life.

His wife became concerned for her husband's welfare, and so she contacted the local police expressing her concern about her husband's safety and the safety of her children. She was afraid that he was becoming very depressed, and thought that he might harm himself and/or the children. She also called her mother, who then went to the defendant's apartment. The police were called to the scene, and the defendant's parents heard on their police scanner that a call had been made to go to their son's apartment; they also drove to the apartment, and were met by the police and their son. By that time, the defendant reported that he, himself, had already called a hotline requesting help with his children. An argument ensued between the defendant and his parents. However, no action was taken by the authorities at this time.

When Halloween came, the defendant's wife returned home so that she and her husband could take their children trick or treating. Then, she spent the night with her husband. It was at this time that he assaulted her and was arrested.

Following the defendant's arrest for sleepwalking, his wife returned to live with her former roommates, and her parents took the four children home for the rest of the night. The next day, DSS contacted her, and notified her that they intended to place the children in foster homes. However, the in-laws intervened, and went to a local court, and received temporary custody of the four children. The two oldest children (both girls) went to live with the defendant's parents, and the two youngest children (girl and boy) went to live with his wife's parents.

Conflicts with in-laws and parents

Throughout their marriage, the defendant's parents have felt that his wife has been the cause of all of his problems, and they have labeled the past nine years as a "living nightmare" for them. They perceive that his wife has had total control over their son, and that she has destroyed previous close relationships with friends and family members that he used to have prior to the marriage. The hatred runs so deep that the defendant reports that his parents told his wife on one occasion: "Why don't you take a bottle of pills, and do us all a favor." He reports that his parents believe that his wife is psychotic and that she has a lover, but he denies that any of these accusations are true. On the contrary, the defendant has felt that his parents have been overly intrusive into his marital matters, and have given unwanted financial and personal advice, and have frequently undermined his decisions and questioned his judgment.

The defendant's mother feels that her son doesn't understand her. She states: "He doesn't see that I'm not his enemy; I've been his friend for years. I'm sorry that my sister and mother died, but that's life. I haven't had much of a life myself!"

Medical history

The defendant's history is negative for major health disorders. He also denies any history of epilepsy. He was hospitalized once previously when he was twelve when he fell out of a tree, and was in a body cast for two to three months.

Criminal history

The defendant has no criminal record.

Psychiatric history

There is no long-term history of inpatient or outpatient treatment. However, the defendant has experienced many years of low self-esteem and low grade chronic depression. In addition, he has recently felt more depressed and experienced suicidal thoughts during the month of October when he was separated from his wife. He also has major unresolved conflictual issues with his parents around self-esteem, anger, and independence/autonomy.

Substance abuse history

There is no history of illicit drug abuse. There is also no long-term history of alcohol abuse, although for the month of October 1989, when he and his wife were separated, he was drinking rum and coca-colas on a nightly basis. Despite this recent pattern of alcohol intake, the resident does not appear to have had a chronic alcohol problem.

Course of pre-trial hospitalization evaluation

During the defendant's pre-trial hospital evaluation at the Taunton Secure Care Unit, he was oriented to time, place, and person, and there were no memory impairments or disturbances in consciousness that might otherwise be suggestive of any organic brain dysfunction. He remained alert to his surroundings, his posture and gait were normal, his eye contact remained good, and there were no abnormal movements. His manner of speaking was normal with regard to quantity, amplitude, and speed, and he related to staff and other residents in a cooperative, trustful, and pleasant manner. There were no signs of major mental illness. His rate of thinking was normal, and there were no disturbances in either the form or content of his thinking. His affect was appropriate to his thought content. He denied experiencing any disorders in sensory perception. However, his prevailing emotional tone appeared to be mildly depressed, consistent with his self-report of his mood prior to his arrest. Depression was particularly manifested by his attitude of self-blame and his guilt over his recent assaultive behavior. He also expressed deep-seated feelings of anger and resentment towards his parents.

During the defendant's hospitalization, the staff did bed checks on the defendant every fifteen minutes. Any unusual behavior, such as tossing and turning, sitting up in bed, mumbling to himself, snoring, walking around his room, or walking around the corridor, was to be charted. During the patient's forty day hospital stay at this program, there was not one single instance of any unusual sleep behavior of any kind. Furthermore, at no time did the resident prove to be a management problem of any kind. He obeyed all program policies and procedure, and participated in all program activities. In light of the correlation between sleep walking behavior and alcohol and caffeine use, loss of sleep resulting in a sleep deficit, and chronic stress, it is not surprising that no instances of sleep walking occurred at our facility since the above factors were not present. He did not receive any psychiatric medications, nor were any prescribed by the staff psychiatrist.

Summary of clinical opinion

It was my clinical opinion that the defendant posed a substantial risk of physical harm to himself and his family as long as his sleepwalking disorder remained untreated. Nevertheless, it was also my opinion that he did not require continued hospitalization since he did not suffer from a substantial mental illness; however, I recommended that his wife and children continue not to live with him until his condition had been successfully treated.

The following recommendations were made to the defendant and were also expressed in the report to the court:

1) I advised the defendant to abstain from alcohol and caffeine intake, and to cease taking over-the-counter diet pills unless he was supervised by a physician.

2) I advised the defendant to maintain a regular adequate sleeping pattern.

3) I advised the defendant not to have any access to a car, guns, or knives.

4) I recommended that he tie his ankle to the bedpost to help prevent him from sleepwalking, and that he have special safety locks placed on his door.

5) I recommended that he continue with outpatient counseling to assist him in resolving longstanding conflicts with his parents.

6) I recommended that he and his wife seek outpatient marital counseling to work on marital issues, especially in light of unresolved conflicts each person has with their own parents.

7) Finally, I recommended that he have a thorough assessment at a sleep disorders clinic, which would include a complete neurological workup, and an overnight evaluation in a hospital sleep lab. I made an appointment for him to be evaluated at a sleep disorders clinic at a Boston hospital. The findings from this assessment are pending.

Upon the defendant's return to court, he pleaded not guilty to the crime, and the court found him not guilty. At the present time, medical and psychological assessment and treatment is continuing, and the defendant's wife has resumed living with him. There has been no further sleepwalking and no further assaults made on her. The couple expects to resume custody of their four children shortly.

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